OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

8 AUG 2017

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This is an interim response to section 712(a) of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328), that requires the Department of Defense to conduct a study of options for providing health care coverage that improves the continuity of health care provided to current and former members of the Selected Reserve of the Ready Reserve.

The enclosed report conveys that the progress to study the options presented in section 712(a) is underway. The report expounds upon the alternatives Congress identified in section 712(a) for Selected Reserve members including: (1) continue TRICARE Reserve Select in its current form; (2) provide a cash allowance to defray the costs of purchasing civilian insurance coverage; and (3) offer subsidized insurance for purchase through a Federal Employees Health Benefit type program.

This interim report is being submitted so the Department can take sufficient time to fully meet the consultation requirement in section 712(a) and include final recommendations from the study required under section 748(a), *Assessment of Transition to TRICARE Program by Families of Members of Reserve Components Called to Active Duty and Elimination of Certain Charges for Such Families*. We will provide a final report, including recommendations in December 2017.

Thank you for your interest in the health and well-being of our Service Members, veterans, and their families. A similar letter is being sent to the Chairman of House Armed Services Committee.

A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

The Honorable William M. "Mac" Thornberry
Chairman
Committee onArmed Services
U.S. House of Representatives
Washington, DC 20515

8 AUG 2017

Dear Mr. Chairman:

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A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Report to Congressional Defense Committees

Interim Report Regarding the Study on Continuity of Health Care Coverage for Selected Reserve

Section 712(a)
National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328)

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Study on
Continuity of Health Care Coverage
for Selected Reserve

Section 712(a) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Public Law 114–328) requires the Department of Defense (DoD) to:

> Conduct a study of options for providing health care coverage that improves the continuity of health care provided to current and former members of the Selected Reserve of the Ready Reserve who are not—
>
> (A) serving on Active Duty;
>
> (B) eligible for the Transitional Assistance Management Program under section 1145 of title 10, United States Code [U.S.C.]; or
>
> (C) eligible for the Federal Employees Health Benefit [FEHB] program.

This report will address the following elements as specified by Congress:

> (A) Whether to allow current and former members of the Selected Reserve to participate in the FEHB program.
>
> (B) Whether to pay a stipend to current and former members to continue coverage in a health plan obtained by the member.
>
> (C) Whether to allow current and [certain] [1] former members to participate in the TRICARE program under section 1076d of title 10, U.S.C.[2]
>
> (D) Whether to amend section 1076f of title 10, U.S.C., as added by section 711, to require the extension of TRICARE program coverage for members of the National Guard assigned to Homeland Response Force Units mobilized for a State emergency pursuant to chapter 9 of title 32, U.S.C.
>
> (E) The findings and recommendations under section 748.
>
> (F) Any other options for providing health care coverage to current and former members of the Selected Reserve the Secretary considers appropriate.

This interim report is being submitted so the Department can take sufficient time to fully meet the consultation requirement in section 712(a)(3) and include final recommendations from the study required under section 748(a).

This interim report expounds upon the alternatives Congress identified in section 712(a) for Selected Reserve members including whether or not to: (1) continue TRICARE Reserve Select (TRS) in its current form; (2) provide a cash allowance to defray the costs of purchasing civilian insurance coverage; and (3) offer subsidized insurance for purchase through a

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[1] Title 10, U.S.C., section 107d, as amended by section 701 of the NDAA for FY 2013 (Pub. L. No. for 112-239; 2013)

[2] Title 10, U.S.C., section 1076d was implemented under title 32, Code of Federal Regulations (C.F.R.) as TRICARE Reserve Select

FEHB-type program. The Department has initiated the study required by section 748, which will provide insight into the challenges being faced by families who wish to continue using their usual providers after their Selected Reserve sponsor has been activated. At this time the Department is not in a position to make any recommendations, because those results will not be available until a later date. However, the Department will continue to provide TRS in its current form pending any potential legislative or policy changes that could result from this completed study.

Background

Providing health care benefits to Reserve Component (RC) members and their families has been the subject of intense discussion both within DoD as well as within Congress. Issues surrounding these discussions include:

- RC member Medical Readiness – Members who have medical issues can adversely affect the readiness of members or units to perform their mission. Improving access to timely and affordable medical care might mitigate this risk.

- Recruitment and Retention – Premium-free health plan coverage (military treatment facilities (MTFs) and TRICARE) has been widely accepted as one of the major benefits that attracts and retains Active Duty personnel. Likewise, health plan coverage can be a benefit that helps the Department meet the personnel requirements for the RCs. Invariably, issues of equity arise when comparing and contrasting health benefits for Active Component personnel and RC members.

- Continuity of Care – During activations (greater than 30 days), it is not uncommon for RC members to be dis-enrolled from their civilian health insurance. While they gain premium-free TRICARE coverage for themselves and their eligible family members, the possibility remains that some of their family's usual providers may not accept TRICARE. RC families with chronic or complex health care needs may experience exacerbated continuity of health care provider issues.

- Access to Care – Many RC members live in locations distant from military bases where access to TRICARE network providers is strongest.

- Readiness of DoD Medical Forces – During activations (greater than 30 days), RC members and their families have access to MTFs. As such their treatment provides more opportunities for DoD medical personnel to keep their skills current.

- Cost – The cost of expanding health benefits for RC members could impact other programs within the Department.

The current system offers a continuum of coverage described in Table 1 below.

Table 1 – Reserve Continuum of Coverage

Health Coverage	Not on Active Duty	On Active Duty	De-activation	Not on Active Duty
TRS family	Active Duty family member benefit in effect (Standard/ Extra)	Full Active Duty TRICARE coverage (including Prime)	TAMP or Active Duty family member benefit in effect	Active Duty family member benefit in effect (Standard/ Extra)
Non-TRS family	Other health insurance	Full Active Duty TRICARE coverage (including Prime)	TAMP or CHCBP or other health insurance	Other health insurance
Currently in effect for Federal Employees Health Benefits (FEHB) program				
FEHB at family premium rates	FEHB family plan	FEHB family plan [a]	FEHB family plan	FEHB family plan

Note: TAMP –Transitional Assistance Management Program. CHCBP –Continued Health Care Benefits Program.

a. FEHB law authorizes Service members enrolled in the FEHB program to continue their FEHB family coverage for 24 months when absent for military duty. For RC members mobilized in support of a contingency operation, their federal agency is authorized to pay the employee's share of the premium.[3] For RC members mobilized other than in support of a contingency operation, the member is responsible for paying the employee's share for the first year then paying both the employer's and employee's share plus an additional 2 percent administration fee for the second year.

I. Elements

This interim report starts with a discussion of the third element as listed in section 712(a), continued participation in TRS. The TRS premium rates are then used in the illustrations for the next element addressed. The option to provide a stipend is referred to as the Basic Allowance for Health Care (BAHC).

A. TRICARE Reserve Select

Selected Reserve members who purchase and maintain their premium-based TRS family coverage when inactivated will have continuity of care with their usual providers (unless their family chooses to enroll in TRICARE Prime, which may be locally available upon activation of their sponsor).

Started in 2005, TRS is the premium-based TRICARE health plan that is available worldwide for purchase by qualified Selected Reserve members to cover themselves and their families. Selected Reserve members qualify to purchase and maintain TRS coverage if they are (a) not sponsored for premium-free TRICARE (i.e., early eligibility TRICARE, active service greater than 30 days, or TAMP) and (b) neither eligible for, nor enrolled in, FEHB program. TRS members pay monthly premiums representing 28 percent of the total premium cost ($47.82 for TRS member-only plans and $217.51 for TRS member and family plans in calendar year 2017[4]). TRICARE Standard/Extra annual deductibles and cost shares (15 percent for TRICARE

[3] http://www.opm.gov/healthcare-insurance/healthcare/eligibility/#url=Reservists

[4] www.tricare.mil/Costs/HealthPlanCosts/TRS

network outpatient visits, 20 percent for non-network visits) apply for covered services. Cost sharing cannot exceed $1,000 annually (catastrophic cap). On average, the Department's share (72 percent) of the 2017 TRS monthly premium cost is $122.97 for the TRS member-only plans and $559.31 for the TRS member and family plans.

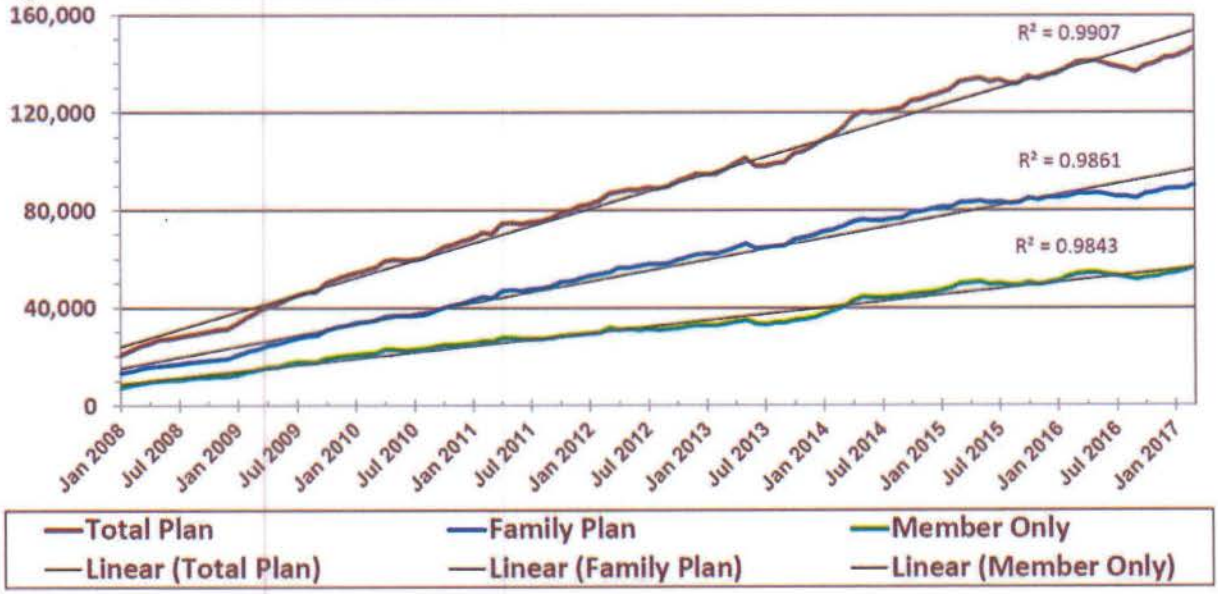
By law, TRS offers TRICARE Standard and Extra coverage as well as MTF care on a space available basis, but not TRICARE Prime coverage.[5] Essentially, TRS offers a comprehensive health benefit with low out-of-pocket costs and a low catastrophic cap welcomed by many Selected Reserve members and their families. About 25 percent of qualified Selected Reserve members hold TRS coverage and DoD has been anticipating the TRS enrollment curve to start flattening since the Affordable Care Act individual mandate went into effect in January of 2014. While both types of coverage increased steadily from 2008 to 2014, the increases in the TRS member and family enrollment might show signs of leveling off while the TRS member-only coverage continues to increase in a linear fashion. Recent TRS enrollment is shown in Table 2 while the enrollment trend over time is shown in Figure 1.

Table 2 – TRS Enrollment

Total TRS Plans	**146,704**
TRS member and family plans	90,307
TRS member-only plans	56,397
TRS Covered Lives	**388,264**

Source: Defense Manpower Data Center as of March, 2017

Figure 1 – TRS Enrollment Trend



[5] TRICARE Standard/Extra coverage for TRS will shift to TRICARE Select coverage as the Department implements section 701 of the NDAA for FY 2017 in 2018; the grandfather provision does not apply to TRS.

Families with TRS family coverage have the easiest transition when their Selected Reserve sponsor is activated (for more than 30 days). They gain premium-free TRICARE and can continue to see their same TRICARE and MTF providers. Upon activation, they are eligible to enroll in available TRICARE Prime programs. TRICARE Prime enrollees who choose to purchase TRS after deactivation revert to TRICARE Standard/Extra coverage.[6]

Despite its advantages, TRS benefits are only realized by those who enroll and pay the premiums. Selected Reserve members who choose another health plan for their families (e.g., employer-sponsored coverage or the Affordable Care Act marketplace) receive no comprehensive health benefit from DoD and might experience transition challenges. This subject will be explored in the study mandated by section 748; TRS actual cost for FY 2016 was $559.420 million and the current estimate for FY 2017 is $578.394 million.

B. Basic Allowance for Health Care

Under the current system, family members of the RC community who maintain other health insurance find themselves shifting to premium-free TRICARE coverage when their RC sponsor is called or ordered to active service for greater than 30 days. In some instances they may need to change health care providers.[7] DoD could help RC members/sponsors maintain continuity of coverage and continuity of individual providers for the family if the RC sponsor were to be offered a stipend to enable the family to continue using their other health insurance coverage when their RC sponsor is activated.

Section 712(a) suggests that an alternative could be to repeal TRS (health plan benefit) and instead offer an allowance (cash benefit) to all Selected Reserve members, this allowance could be used towards premium costs of a health plan of their choice from sources personally available to them such as their employer or an Affordable Care Act marketplace. The Military Compensation and Retirement Modernization commission established by Congress is credited with developing a notion of a BAHC.[8] A RC BAHC alternative could expand benefits to the total Selected Reserve force beyond the 25 percent of qualified RC members who currently invest in TRS.

The BAHC could be structured so that the total cost to the DoD was similar to its current outlay for TRS. To illustrate, DoD currently spends about $560 monthly per TRS family. If this amount was spread across all eligible Selected Reserve members, each family could receive an allowance of about $140 monthly, but the new benefit would benefit four times as many families.[9] While it would help to defray the cost, it is doubtful it would fully cover the RC members' portion of their civilian premiums. It is likely that those currently using TRS would see an increase in out-of-pocket health care costs (both premiums and cost-sharing), but those who currently use their civilian insurance would see a reduction in their out-of-pocket premium

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[6] TRICARE Select in 2018

[7] The extent of problem for continuity of care for family members is the focus of the study underway for section 748 of the NDAA for FY 2017.

[8] www.mcrmc-research.us

[9] Since Selected Reserve members are expected to perform a minimum of four drills a month on average, one approach could be to accrue 25 percent of monthly amount per drill performed which would be about $35/member/drill period.

costs.[10] Members would have to demonstrate proof of coverage to get the BAHC. While a BAHC election would impose a lock-out from TRICARE to include MTF care and MTF pharmacy, it has the potential to preserve continuity of care.

Furthermore, the sponsor could elect (a) to continue BAHC when activated in order to continue their civilian family coverage (with the cost offset) or (b) TRICARE under current rules. The BAHC during the activation period could be increased to account for the larger cost that DoD currently assumes during an activation. For illustration purposes, the maximum BAHC could be estimated as the amount not exceed the TRS full family premium ($776.82 in 2017) minus the member-only full premium ($170.79). The resulting 2017 BAHC would be $606.03 monthly ($7,272 annualized). Sponsors with families could be eligible for the BAHC when the Selected Reserve sponsor is called or ordered to active service for more than 30 days, but less than two years. The election of BAHC or TRICARE would be a one-time event per activation, unless the other health insurance is lost during that period.

C. Federal Employees Health Benefit Program Model

Section 712(a) suggests that an alternative could be to repeal TRS and offer Selected Reserve members an opportunity to choose among a variety of health plans under a program modeled after the FEHB program. The pilot as provided in section 712(b) would vary significantly from the FEHB program as currently operated by Office of Personnel Management (OPM) in the following manner.

- The 712(b) pilot program would not include pharmaceutical benefits. Presumably pilot participants would revert to programs under chapter 55 of title 10, U.S.C., for pharmaceutical benefits.
- MTFs could contract with pilot program carriers to provide carrier-covered services to pilot participants on a fully reimbursable basis (i.e., plans would pay MTFs for care received by pilot participants).
- A plan would drop the Selected Reserve member from pilot coverage during any period in which the member was on active service for more than 30 days, but pilot coverage would continue uninterrupted for any family member on the plan (and premiums would need to adjust accordingly). Presumably the activated member/sponsor would gain (revert to) coverage in programs under chapter 55 of title 10, U.S.C.
- Premiums payable by the Selected Reserve sponsor would be exactly 28 percent of the particular health plan in which the member enrolled, (rather than the weighted average approach the current FEHB program uses that establishes an upper limit of 75 percent to the government's share of the premium for any particular plan).[11]

The resulting program would be significantly different from the legacy FEHB program with its annually posted premiums. A separate program for the pilot would mean a separate risk pool for DoD beneficiaries that would account for demographic differences between the pilot

[10] This BAHC may be viewed inequitable to RC families that may not have an option.
[11] Title 5, U.S.C. § 8906

population and the legacy FEHB program population. While this could substantially lower premiums compared to the legacy FEHB program, it is more than likely that the resulting premium would still be higher than current TRS premiums.

Additionally, it is uncertain whether there would be enough demand for these pilot products to establish a viable risk pool. In any given region, limited numbers of Selected Reserve members exist and historical experiences have shown few DoD beneficiaries choose to participate in such pilot FEHB programs. OPM could have difficulty attracting carriers to compete for such a small population, leaving the Selected Reserve population with a more narrow set of choices, most likely limited to nationwide plans. Despite these reservations, DoD has begun discussions with OPM regarding the feasibility and advisability of a limited pilot. A pilot could give insight into carrier and members' interest.

The OPM-operated FEHB program is the largest employer-sponsored group health insurance program in the world, covering over 8 million federal employees, retirees, former employees, family members, former spouses, and other certain individuals.[12] Historically, it has been regarded as a model employer-sponsored group health insurance program. The FEHB program became effective in 1960.[13] It is governed by law under chapter 89 of title 5, U.S.C., and implemented under the Code of Federal Regulations in part 890 of title 5 and chapter 16 of title 48. OPM administers the program through "evergreen" (perpetual) contracts that are subject to premium rate negotiations each year. The FEHB handbook provides the program policies and procedures. Strategic direction to the potential carriers is provided through an annual call letter and technical guidance, supplemented by specific carrier letters.[14]

The program offers a choice of nationwide plans as well as regional plans that are available by locality. The various health plans offered under the program operate under their plan brochures submitted annually to OPM for acceptance for the coming year. Carrier brochures accepted by OPM are, in essence, considered to be contractually binding. Plan types include health maintenance organizations, fee-for-service plans, preferred provider organizations, and consumer-driven health plans. All plans must offer comprehensive coverage (i.e., meet or exceed the Affordable Care Act requirements for minimum essential coverage), but carriers compete for eligible subscribers on price, networks, additional covered benefits, delivery system design, quality, and satisfaction.

For full-time employees, federal agencies contribute 72 percent of the weighted average of premium costs for the FEHB plans offered in a particular year. However, the government contribution cannot exceed 75 percent of the subscription charge.[15] For non-postal family plans offered in calendar year 2017, the federal agencies paid up to $13,135.68 annually ($1,094.64 monthly) towards the total cost of the premium,[16] not to exceed 75 percent of the total cost of the premium for a particular carrier plan. Subscribers who enroll into plans with above average premium costs are responsible for the excess premium costs.

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[12] www.opm.gov/healthcare-insurance/healthcare/reference-materials/fehb-handbook
[13] Public Law 86-382, enacted September 28, 1959.
[14] www.opm.gov/healthcare-insurance/healthcare/carriers/#url=Carrier-Letters
[15] Title 5, U.S.C. § 8906
[16] www.opm.gov/healthcare-insurance/healthcare/plan-information/premiums

One variation from the section 712(b) provisions could be a pilot allowing Selected Reserve members to join the established FEHB program with DoD providing a subsidy equivalent to the amount federal agencies contribute to the premium cost of each carrier plan. This would give Selected Reserve members the choice of any FEHB plan to meet their individual household's needs and preferences. Again, beneficiary out-of-pocket expenses for both premiums and cost-sharing in addition to Department costs would likely be substantially higher when compared to TRS.

D. Coverage by TRICARE for Member/Families during State National Guard Duty

The Department is in the process of implementing section 1076f of title 10, U.S.C., as added by section 711 of the NDAA for FY 2017, which requires the extension of TRICARE program coverage for members of the National Guard assigned to Homeland Response Force Units mobilized for a State emergency pursuant to chapter 9 of title 32, U.S.C.

E. Findings and Recommendations under Section 748

DoD has contracted with the federally funded research and development center, Center for Naval Analysis, to conduct the study required under section 748. This study will help the Department understand the unique problems RC members face, especially during the transition periods in the course of activation greater than 30 days. Focus groups, surveys, and data analysis will lead to a better understanding of potential solutions to the actual problems encountered by RC and their families. Once those results are known, the Department will be in a better position to make recommendations.

F. Other Health Care Coverage Options Considered for the Selected Reserve

This will be addressed in the final report after the section 748 study is finished.

II. Conclusion

This interim report has expounded upon the alternatives Congress identified in section 712(a) for Selected Reserve members including: (1) continue TRS in its current form; (2) provide a cash allowance to defray the costs of purchasing civilian insurance coverage; and (3) offer subsidized insurance for purchase through a FEHB-type program. The Department has initiated the study required by section 748, which will provide insight on the challenges being faced by families who wish to continue using their usual providers after their Selected Reserve sponsor has been activated. However, those results will not be available until a later date. Therefore, at this time the Department is not in a position to make any recommendations. Nevertheless, the Department will continue to provide TRS in its current form pending any potential legislative or policy changes that could result from this completed study.